Welcome

SALAMA CHIROPRACTIC CENTER

Patient Information

Date _____

Patient Name _____
First Name

_____
Middle Initial Last Name

Address _____

City _____

State _____ Zip _____

Sex ❑ M ❑ F Age _____

Social Security # _____

Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

E-mail _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Phone _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

How did you hear about our office? _____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No

Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable)

_____

Insurance

Health Insurance Name _____

Who is the primary insured? _____

What is the date of birth of the primary insured? _____

Relationship to Patient _____

Insured's DOB _____ Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No If yes...

2nd Insurance Co. Name _____

Subscriber's Name _____

Birthdate _____

Relationship to Patient _____

Group # _____

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Salama Chiropractic Center and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Salama Chiropractic Center of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Salama Chiropractic Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Salama Chiropractic Center for all covered medical services and supplies provided to me during all courses of treatment and care provided by Salama Chiropractic Center and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Salama Chiropractic Center, and will constitute a continuing authorization, maintained on file with Salama Chiropractic Center, which will authorize and allow for direct payment to Salama Chiropractic Center of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Salama Chiropractic Center.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient